

A Brief History of Health Services Prioritization in Oregon

Background

In 1987, the Oregon Legislature realized that it had no method for allocating resources for health care that was both effective and accountable. Over the next two years, policy objectives were developed to guide the drafting of legislation to address this problem. These policy objectives included:

- Acknowledgment that the goal is health rather than health services or health insurance
- Commitment to a public process with structured public input
- Commitment to meet budget constraints by reducing benefits rather than cutting people from coverage or reducing payments to levels below the cost of care
- Commitment to use available resources to fund clinically effective treatments of conditions important to Oregonians
- Development of explicit health service priorities to guide resource allocation decisions
- Commitment to maintain the integrity of the prioritization process, including a prohibition against changes to the priorities as part of Legislative funding decisions

The strategy was to move away from “rationing” by excluding people from health coverage or reducing access through underpayment. Instead, when budget limits required reductions in budget costs, health services would be eliminated according to explicit priorities established by an independent commission in an accountable, public process.

Based on these policy objectives, legislation was passed in 1989 creating the Health Services Commission, charged with developing a list of health services prioritized from most important to least important to the entire population to be covered.¹ Commission membership is stipulated in statute and must include 5 physicians, one public health nurse, and one social worker with the remaining 4 representing purchasers and consumers of health care.

Methodology

In setting about its work, the Commission immediately realized that it required the best available information on clinical effectiveness in order to set meaningful priorities,

¹ Although it was envisioned at this time that the prioritized list would determine the minimum acceptable benefit package for all Oregonians, in fact the only application has been to determine covered benefits for those covered by Medicaid.

and that specificity would be necessary in defining a particular service for a particular condition. A review of outcomes studies revealed that clinical experience would need to be the basis for identifying outcomes for most treatments. Accordingly, the Commission worked with hundreds of specialists and sub-specialists to gauge the relative effectiveness of thousands of condition/treatment (CT) pairs defined in terms of ICD-9-CM and CPT-4 codes. Probable health outcomes for a given condition were compared for a) a given treatment, b) alternative treatments, and c) with no treatment at all.

In addition to this information on clinical effectiveness, the Commission also requested information on public values concerning health care. Three methods were used to gather this public input: 1) twelve public hearings in which testimony was taken from Oregonians concerning their health care experiences and preferences; 2) approximately 50 focus groups around the state in which facilitators helped citizens to identify health values on which there was some degree of consensus; and 3) a survey of 1001 Oregonians to identify the impact on overall health resulting from a broad range of hundreds of conditions such as shortness of breath, limited range of motion, social dysfunction, and hearing loss. These three methods provided the Commission with a sense of the relative importance of treating a condition as expressed by those who would be covered by the benefit package resulting from the prioritization of services.

Finally, the Commission requested information from a consulting actuary on the cost of the services being prioritized. These cost data were based on paid claims experience in both Medicaid and private insurance, and were used to develop relative cost factors.

The first approach to prioritization the Commission tried was formulaic. It used the following formula to derive cost/benefit values for each CT pair, and then ranked these C/T pairs as health services accordingly:

$$B_n = \frac{c}{Y * \left[\sum_{i=1}^5 (p_{i1} * QWB_{i1}) - \sum_{i=1}^5 (p_{i2} * QWB_{i2}) \right]}$$

[With Treatment] [Without Treatment]

$$\text{with } QWB_k = 1 + \sum_{j=1}^{30} d_{jk} w_j \quad k=1,2$$

where:

- B_n = the net benefit value ratio for the nth condition/treatment pair to be ranked.
- c = cost with treatment, including all medications and ancillary services as well as the cost of the primary procedure.
- Y = the years for which the treatment can be expected to benefit the patient with this condition.
- $[term]$ = the difference in probability weighted QWBs with and without treatment.
- QWB = subjectively weighted sum of health limitations associated with a specific outcome.

The result was unacceptable because it conflicted substantially with the judgment of all Commission members, physician and non-physician. In brief, the problem was that very inexpensive, very effective treatments for trivial conditions (e.g. malocclusion due to thumb sucking) ranked higher than moderately expensive, moderately effective treatments for very serious conditions. The lesson learned was that while a cost/benefit analysis can gauge the cost of remedying a condition, it cannot address the importance of treating the condition in the first place. The Commission's response was to abandon the cost/benefit formula and base its prioritization on general categories of treatment, which were ranked to reflect relative importance based on public input. These categories include:

- Category 1: Acute fatal condition, treatment prevents death with full recovery
- Category 2: Maternity care
- Category 3: Acute fatal condition, treatment prevents death without full recovery
- Category 4: Preventive care for children
- Category 5: Chronic fatal condition, treatment improves life span and quality of life
- Category 6: Reproductive services (excluding maternity and infertility services)
- Category 7: Comfort care
- Category 8: Preventive dental care
- Category 9: Proven effective preventive care for adults
- Category 10: Acute non-fatal conditions, treatment causes return to previous health state
- Category 11: Chronic non-fatal condition, one-time treatment improves quality of life
- Category 12: Acute non-fatal condition, treatment does not result in a return to previous health state
- Category 13: Chronic non-fatal condition, repetitive treatment improves quality of life
- Category 14: Self-limiting conditions where treatment expedites recovery
- Category 15: Infertility services
- Category 16: Less effective preventive care for adults
- Category 17: Fatal or non-fatal condition, treatment causes minimal or no improvement in quality of life

Within these ranked categories, specific services were prioritized based on cost and effectiveness. The Commission also established three subcommittees: the Mental Health Care and Chemical Dependency Subcommittee, the Aged, Blind and Disabled Subcommittee, and the Health Outcomes Subcommittee. These subcommittees helped to ensure that the needs of vulnerable populations were taken into account, and that the best information on health outcomes was continually available to the Commission as it established and maintained prioritized list.

As a final step in prioritizing health services, Commission members moved C/T pairs "by hand" to assure that the prioritized list reflected their best judgment as clinicians and as representatives of those to be covered under the resulting benefit package.

At this point in the development of the first prioritized list, an unforeseen political problem emerged. Attorneys within the federal Department of Health and Human Services interpreted the Americans with Disabilities Act in such a way that they construed the Commission's methodology for setting priorities to be in conflict with that law. As a result, the Commission was required to remove all public input obtained from the survey described above. The first federal position was that priorities should be based completely on three factors: first, whether the treatment prevents death; second, the cost of the treatment, and third, on alphabetical order. This position was rejected by the Commissioners, who argued that their collective judgment should also be a factor. Federal attorneys agreed, and Commissioner judgement was applied with the result that many public values on health that had been expressed in the survey were reflected in the final prioritization.

Since it was first completed in 1992, the prioritized list of health services has been revised every two years as part of Oregon's biennial budget process. An example of a change resulting from these biennial revisions is the movement of cochlear implants to a higher position based on improved outcomes information. Additionally, interim modifications can be made to the list between biennial reviews to account for changes in medical codes and medical advancements that need immediate attention. Examples of the latter include a higher placement for chronic hepatitis C with the treatment of interferon and the inclusion of services related to physician assisted-suicide when that became legal in the state of Oregon.

Impact

The prioritized list has succeeded in making decisions about the allocation of public resources for health coverage more explicit and accountable. It has also succeeded in making health policy more reflective of the best evidence available on clinical effectiveness, and more reflective of the preferences of those affected by these health policy decisions. Also, physician practice has altered over time to reflect the benefits defined by the prioritized list.

However, the prioritized list has not succeeded in shifting responses to budget constraints entirely to reductions in benefits. This is because the federal government has refused to allow Oregon to reduce benefits when revenues decline, forcing the state to make adjustments in eligibility and in payment levels to keep within budget. This political constraint has prevented a full exploration of the effectiveness of the prioritization of services in meeting budget limits while maintaining the commitment to cover all those in need and the commitment to pay providers at levels sufficient to cover the cost of care. And even if Oregon were free to move the line further, the range just above line 560 begins to include treatable cancers and other serious but treatable conditions. The Commission is currently reviewing this section of the prioritized list to

determine whether some lines ought to be moved, either up or down, based on the latest information on outcomes.

Since its inception, over 1 million Oregonians have been covered under the prioritized list. Most of these have been in managed care, and many participating managed care plans have developed mechanisms for accommodating practice patterns to the benefit package defined by the list.

The prioritized list has had a modest impact on costs per member per month. The actuary estimates that the cost with the line drawn so that 560 of the 720 lines are covered is approximately 90% of what the cost would be if all 720 lines were covered. The reason the impact is not greater is that much of the more expensive care is found high on the list. In fact, diagnostic services are in effect ranked at line 0 in the sense that the cost of arriving at a diagnosis is always covered.

Public support for the prioritization process has never weakened, and the integrity of the prioritized list has never been questioned by providers or consumers of health services. Moreover, the legislators who make the decisions on allocating public resources for health care have accepted the independence of the prioritization process from the actions of the legislature.

Most recently, the Commission developed a second prioritized list at a much more summary level. This list prioritizes broad categories of service (e.g. hospital inpatient, physician, prescription drugs, mental health) and identifies cost sharing levels for each category of service at each priority level (so that a given category of service may appear more than once on the list with two or more levels of cost sharing). This methodology does not require analysis at the ICD-9/CPT-4 level, and its goal is to develop a public program benefit package that approximates the typical private insurance benefits purchased by Oregon businesses for employees.

The first prioritized list overlays the prioritized categories of services so that within a category (e.g. physician care) nothing is covered that is not “above the line” on the prioritized list of health services. What is not covered for OHP Plus is also not covered for OHP Standard. Both the prioritized list of health services (now called “OHP Plus” benefits) and the prioritized categories of services and cost sharing (called “OHP Standard”) are available on the OHPR web site (www.ohpr.state.or.us).